

# ALLINA HEALTH AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Internal Use Only      Completed By Initials : \_\_\_\_\_ Date: \_\_\_\_\_

<b>PATIENT INFORMATION</b>	Patient name			Date of Birth	
	Street Address			Email Address	
	City	State	Zip Code	Phone Number	
<b>RELEASE MY MEDICAL RECORDS FROM</b> <b>**check one option</b>	<input type="checkbox"/> Allina Health (optional: specify location or provider below):		<b>OR</b>	<input type="checkbox"/> Hospital/Clinic/Provider (required: specify name below)	
	Street Address			Phone Number	
	City	State	Zip Code	Fax Number	
<b>SEND MY MEDICAL RECORDS TO</b> <b>**address field is required</b>	Person/Business/Hospital/Clinic		Phone Number		Fax Number
	Street Address		City	State	Zip Code
<b>PURPOSE FOR RELEASE</b>	<input type="checkbox"/> Continuing Care <input type="checkbox"/> Personal Use/Review * <input type="checkbox"/> Litigation/Legal * <input type="checkbox"/> Insurance Application * <input type="checkbox"/> Insurance Payment/Claim <input type="checkbox"/> Social Security Disability * <input type="checkbox"/> Social Security Appeal <input type="checkbox"/> Disability Insurance <input type="checkbox"/> Other * _____ <i>*Fees may be charged in accordance with MN Statute 144.2923 and Federal Rule 45 C.F.R. §164.524</i>				
<b>INFORMATION TO BE RELEASED:</b>  <b>What Information do you want disclosed?</b>	<b>I want my records related to:</b> _____ <b>I want my records for dates of service:</b> _____ <input type="checkbox"/> Billing Records* <input type="checkbox"/> Community Pharmacy* <input type="checkbox"/> Pathology Slides/Blocks* <input type="checkbox"/> Radiology Images*    ( <i>*Will be sent separately</i> ) <input type="checkbox"/> Clinic Record Set (office visit notes, lab, radiology report, med list, immunizations) <input type="checkbox"/> Hospital Record Set (history & physical, discharge summary, operative report, consultations, emergency records, lab, radiology report)				
	<u>Individual Report Options:</u> <input type="checkbox"/> Discharge Summary/Note <input type="checkbox"/> Clinic/Progress Notes <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Immunization Record <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Emergency/Urgent Care <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Allergy Record <input type="checkbox"/> Operative Report <input type="checkbox"/> Rehab Notes (PT/OT/ST/RT) <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Medication Records <input type="checkbox"/> Consultations <input type="checkbox"/> Home Health/Hospice <input type="checkbox"/> EKG/ECHO <input type="checkbox"/> Any and All Records (includes <u>ALL</u> types of records at Allina Health) <input type="checkbox"/> Other Records (specify type): _____				
<b>Special Disclosure Permissions</b>	<input type="checkbox"/> Chemical Dependency/Substance Use Program Records <input type="checkbox"/> Genetic Counseling Records <b>Wisconsin Records Only:</b> <input type="checkbox"/> Mental Health Records <input type="checkbox"/> HIV Test Results				
<b>RELEASE METHOD/FORMAT</b>	<span style="color: red;">▶ Date Records are Needed (appointment date): ____/____/____ (NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)</span>				
	<input type="checkbox"/> Allina Health My Account (MyChart) <input type="checkbox"/> U.S. Mail (Paper) <input type="checkbox"/> U.S. Mail (CD/DVD) <input type="checkbox"/> Fax (Patient Care Only-See Above) <input type="checkbox"/> Non-Secure Email* (to Patient Only-See Above) <input type="checkbox"/> Secure Email : _____ <input type="checkbox"/> Verbal (no records will be sent) <input type="checkbox"/> Pick Up at Allina Health Commons (by appt only) <input type="checkbox"/> View Record <small>*NOTE: I acknowledge that by electing to receive my health information via email in a non-secure manner that the information will not be encrypted, and that it could be intercepted and viewed by a third party. Allina Health is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.</small>				
<ul style="list-style-type: none"> <li>• This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: ____/____/____. This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Allina Health Notice of Privacy Practice describes how to cancel (revoke) this authorization.</li> <li>• Allina Health will not restrict my treatment if I choose not to sign this authorization.</li> <li>• A photocopy/fax of this authorization will be treated in the same way as an original.</li> <li>• Allina Health records may include records that it received from other organizations. If these records have been used by Allina Health and filed in the record Allina Health maintains about you, these records may be released with your Allina Health records.</li> <li>• Allina Health cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Allina Health from any and all liability resulting from a redisclosure by the recipient.</li> <li>• Federal Rule 42 CFR part 2 prohibits unauthorized disclosure of Substance Use Program Records</li> <li>• Your signature indicates that you have read and understand this form, and authorize release of your information as described above.</li> </ul>					

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authority to act on behalf of patient (attach document)

## Directions for Completion of Form

**Patient Information:** Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual about whom information is being requested)

**Release My Medical Records From:** Check the first box if you would like your records released from an Allina Health facility/provider. Check the second box if you are requesting your records be released from a **non**-Allina Health facility/provider. When checking the Allina Health option, please specify the specific Allina Health location you are seeking information from. **Please be specific** in your request. For example, United Hospital, St. Paul, MN; Buffalo Hospital, Buffalo, MN; Allina Medical Clinic Shoreview, Shoreview, MN. If you do not identify a specific hospital or clinic (e.g. Allina Health), records may be provided from **ALL** Allina Health hospitals or clinics where you have received care. Please see [allinahealth.org/medical-records](http://allinahealth.org/medical-records) for a listing of Allina Health hospital and clinic locations and addresses.

**Send My Medical Records To:** Identify the full name/business, address, phone and contact information with the name of the individual who is *to receive* the information. *Please allow 7-10 days for all requests to be processed and sent to the recipient.*

**Purpose For Release:** Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

**Information to Be Released:** This section gives us the instructions for what information you want released. If you select "Clinic Record Set" or "Hospital Record Set", we will disclose the pertinent documents that are specific to that type of patient care visit. This is typically what doctors' offices, hospitals or other health care providers need to provide information related to your care. If you select "any and all" records, your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates, needed by the requestor. Please note record types listed in the Special Disclosure Permissions section must be checked in order for them to be released.

**Release Method:** This tells us how you would like your information delivered. If you wish to view information prior to selection of documents, please identify this on the authorization form and we will contact you to set up a viewing appointment. Please note that viewing appointments are done at the Allina Health Corporate Office in Minneapolis. If you wish information about you to be shared verbally or for an authorization to be on file for others to have access to your medical information, please write this in this section (example: form on file for access by my husband upon his specific request). Please note: there are size limitations when emailing records.

Duration of the authorization, revocation and other information you need to know: This authorization will automatically expire in 12 months **unless** you include a different date. You may indicate the authorization is valid "5 years", "10 years", but there needs to be an ending date (do **not** use terms such as "lifetime" or "forever"). The authorization can be revoked by your written direction to our organization.

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### Contact Information for Patient Record Copies

\*\*\*Incoming medical records are **not** to be sent to this department\*\*\*

Allina Health  
Attn: Health Information/ROI – Mail Route 10203  
PO Box 43  
Minneapolis, MN 55440-0043  
Phone: 612-262-2300  
Fax: 612-262-2323  
Email: [MedicalRecords@allina.com](mailto:MedicalRecords@allina.com)

### Contact Information for Allina Health Pharmacy Charges Copies Allina Health Pharmacy – Mail Route 10807

Allina Health  
PO Box 43  
Minneapolis, MN 55440-0043  
Phone: 612-262-5980  
Fax: 612-262-5988

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Plate: Black

**For a list of Allina Health locations and addresses, please visit [allinahealth.org](http://allinahealth.org)**